Application for

Section 1915(b) (4) Waiver
Fee-for-Service
Selective Contracting Program

v1.0

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Fee-for-Service (FFS) Selective Contracting Program

Facesheet

The **State of Maryland** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is **Home and Community-Based Options (formerly known as Waiver for Older Adults)**.
(List each program name if the waiver authorizes more than one program.).

Type of request. This is:
___ an initial request for new waiver. All sections are filled.
___ a request to amend an existing waiver, which modifies Section/Part **A**.
X a renewal request

Section A is:
___ replaced in full
___ carried over with no changes
X changes noted in **BOLD**.

Section B is:
___ replaced in full
X changes noted in **BOLD**.

Effective Dates: This waiver amendment is requested for the period of **2/1/2017** to 6/30/2021.
State Contact: The State contact person for this waiver is **Lorraine Nawara** and can be reached by telephone at (410) 767-**1442**, or fax at (410) 333-5362 or e-mail at **lorraine.nawara**@maryland.gov.

Section A – Waiver Program Description

Part I: Program Overview

Tribal Consultation:
Describe the efforts the State has made to ensure that Federally-recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

In accordance with Section 1902(a)(73) of the Social Security Act, Maryland Medicaid seeks advice on a regular, ongoing basis from designees including Maryland's Urban Indian Organization. In November, 2010, the State appointed a designee of the Urban Indian Organization to the Maryland Medicaid Advisory Committee (MMAC). The MMAC meets monthly and receives updates on demonstration projects, pertinent policy issues, waivers, regulations and State Plan Amendments (SPAs) for all Medicaid Programs. These communications occur prior to the submission of waivers, amendments and other policy changes. Maryland also consults with the Urban Indian Organization on an as needed basis to develop SPAs and regulations which will have a direct impact on access to health care systems as well as the provision of care/services for Indian populations.

On April 8th 2016, The State contacted the Urban Indian Organization about this amendment. The UIO responded on that day that they had no comments.

Program Description:
Provide a brief description of the proposed selective contracting program or, if this is a request to amend an existing selective contracting waiver, the history of and changes requested to the existing program. Please include the estimated number of enrollees served throughout the waiver.

The waiver requested is limited to the case management services in the existing 1915(c) waiver, Home and Community-Based Options.
This waiver provides services, including case management to adults ages 18 and over who meet nursing facility level of care. Under the 1915(b)(4) authority, the State currently waives the freedom of choice of providers for case management services offered under the 1915(c) authority. The Area Agencies on Aging (AAAs) **and Local Health Departments (LHDs)** will be designated providers, and competitive solicitation will continue to identify one or more providers per region to offer a limited choice of providers to the participants within each region.

Waiver Services:
Please list all existing State Plan services the State will provide through this selective contracting waiver.

Waiver case management services.

A. Statutory Authority

1. **Waiver Authority.** The State seeks authority under the following subsection of 1915(b):

   X **1915(b) (4) - FFS Selective Contracting program**

2. **Sections Waived.** The State requests a waiver of these sections of 1902 of the Social Security Act:

   a.___ **Section 1902(a) (1) - Statewideness**
   b.___ **Section 1902(a) (10) (B) - Comparability of Services**
   c. X **Section 1902(a) (23) - Freedom of Choice**
   d.___ **Other Sections of 1902** – (please specify)

B. Delivery Systems

1. **Reimbursement.** Payment for the selective contracting program is:

   ___ the same as stipulated in the State Plan
   X is different than stipulated in the State Plan (please describe)

In accordance with COMAR 10.09.54.22, a fee schedule shall be published at least annually by the Department, and the rates are increased on July 1 of each year, subject to the limitations of the State budget, by the lesser of 2.5% or the percentage of the annual increase in the March Consumer Price Index for All Urban Consumers, all items component, Washington-Baltimore, from the U.S. Department of Labor, Bureau of Labor Statistics. The Office of Health Services implements rate adjustments in accordance with these regulatory provisions.

2. **Procurement**. The State will select the contractor in the following manner:

   ___ **Competitive** procurement
   ___ **Open** cooperative procurement
   ___ **Sole source** procurement
   _X_ **Other** (please describe)

   The State of Maryland will designate up to 19 area agencies on aging (AAAs) (the total number of AAAs in the state**) and up to 24 local health departments (the total number of LHDs in the state)** as case management providers and will also use a competitive solicitation process to identify additional providers. Since the rate will be set in regulation, the proposals will be evaluated solely on quality and experience.

C. Restriction of Freedom of Choice

1. **Provider Limitations**.

   ___ Beneficiaries will be limited to a single provider in their service area.
   _X_ Beneficiaries will be given a choice of providers in their service area.

The State intends to have at least two providers per county. Supports Planning Agencies (SPAs) are identified through a competitive solicitation process. There is one AAA in every county. Montgomery County has 4 other SPAs; all other counties have 3 other SPAs.

Allegany County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Anne Arundel County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Baltimore County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Baltimore City	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Calvert County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Caroline County	Area Agencies on Aging (AAA)	Bay Area Center for Independent Living (BACIL)	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Carroll County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Cecil County	Area Agencies on Aging (AAA)	Bay Area Center for Independent Living (BACIL)	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Charles County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Dorchester County	Area Agencies on Aging (AAA)	Bay Area Center for Independent Living (BACIL)	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Fredrick County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Garrett County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Harford County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Howard County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Kent County	Area Agencies on Aging (AAA)	Bay Area Center for Independent Living (BACIL)	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Montgomery County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	Independence Now

Prince George's County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Queen Anne's County	Area Agencies on Aging (AAA)	Bay Area Center for Independent Living (BACIL)	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
St. Mary's County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Somerset County	Area Agencies on Aging (AAA)	Bay Area Center for Independent Living (BACIL)	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Talbot County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Washington County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Wicomico County	Area Agencies on Aging (AAA)	Bay Area Center for Independent Living (BACIL)	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Worchester County	Area Agencies on Aging (AAA)	Bay Area Center for Independent Living (BACIL)	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	

2. **State Standards.**

Detail any difference between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents.

Two providers per county is the minimum but not the norm. We strive for, and have provided, more options. A minimum of two providers ensure choice of provider and adequate coverage. Agencies have more staff in more populated areas of the state.

D. Populations Affected by Waiver

(May be modified as needed to fit the State's specific circumstances)

1. **Included Populations**. The following populations are included in the waiver:

___ Section 1931 Children and Related Populations
___ Section 1931 Adults and Related Populations
_X_ Blind/Disabled Adults and Related Populations
___ Blind/Disabled Children and Related Populations
_X_ Aged and Related Populations
___ Foster Care Children

___ Title XXI CHIP Children

2. **Excluded Populations.** Indicate if any of the following populations are excluded from participating in the waiver:

___ Dual Eligibles
___ Poverty Level Pregnant Women
___ Individuals with other insurance
___ Individuals residing in a nursing facility or ICF/MR
___ Individuals enrolled in a managed care program
___ Individuals participating in a HCBS Waiver program
___ American Indians/Alaskan Natives
___ Special Needs Children (State Defined). Please provide this definition.
___ Individuals receiving retroactive eligibility
_X_ Other (Please define): The population covered for this waiver is limited to applicants and enrollees of the 1915(c) Home and Community-Based Options Waiver.

Part II: Access, Provider Capacity and Utilization Standards

A. Timely Access Standards

Describe the standard that the State will adopt (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has adopted) defining timely Medicaid beneficiary access to the contracted services, *i.e.*, what constitutes timely access to the service?

1. How does the State measure (or propose to measure) the timeliness of Medicaid beneficiary access to the services covered under the selective contracting program?

Timely access for case management will be defined in the procurement documents and provider agreements. The State uses a web-based LTSS tracking system to monitor programs and it will use this system to monitor service provision of the covered services.

Individuals who are referred to the Community First Choice program are provided information brochures about all the supports planning agencies that serve their geographic area. Participants are encouraged to call the provider of their choice to select them and get access to services. If participants do not contact an agency to select them directly, the system will assign the individual to a provider on 21st day. This system check ensures all participants are assigned to a supports planning agency.

All Supports Planning Agencies are required to sign a provider agreement and adhere to the Provider Solicitation (Comprehensive Case Management and Supports Planning Services for Medicaid Long-Term Services and Supports). Section 3.4 of the Provider

Solicitation outlines services for applicants and specifies contact should be made with the participant within 14 calendar days of assignment to their agency. Section 3.6 of the Provider Solicitation requires supports planners to make direct contact with participants as needed and at minimum every 30 days with a quarterly home visit every 90 days.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiaries are unable to access the contracted service in a timely fashion.

   The State will require a corrective action plan for a provider that fails to meet timely access standards. In the event the providers fail to meet timely access standards under the CAP, the State will take action based on the following procurement rules:

During the current waiver period, 12 Corrective Action Plans (CAP) were issued for delays in supports planning agencies submitting plans of service. No CAPs were issued for delays in assigning a supports planner. All agencies were required to submit the following in response to the plan of service timeliness CAP:

1. Description of the quality assurance plan in place to identify delays in timely services, including names of staff responsible for implementing the plan;
2. A list of all active applicants and participants that includes the date of the assessment, the date the plan of service (POS) was submitted to the Department, and a calculation of the days to submission of the POS.
3. A calculation of the average days to POS submission across the agency and per individual supports planner;
4. The total number of plans currently overdue with the days each plan is overdue;
5. Description of the remediation process in place to address these delays;
6. Training materials for staff that include time frames and the quality assurance process;
7. An indication of what has been done to address this matter; and
8. An action plan that will be put in place to prevent a reoccurrence of this situation.

All CAP responses reviewed and approved at Department. All SPA agencies have assigned liaison from the Department who provides technical assistance and monitors adherence to established quality plans.

A. Provider Capacity Standards

Describe how the State will ensure (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has ensured) that its selective contracting program provides a sufficient supply of contracted providers to meet Medicaid beneficiaries' needs.

1. Provide a detailed capacity analysis of the number of providers (e.g., by type, or number of beds for facility-based programs), or vehicles (by type, per contractor for

non-emergency transportation programs), needed per location or region to assure sufficient capacity under the selective contracting program.

The State requires any AAA **or LHD** that chooses to provide supports planning to establish a maximum number of people they are able to serve. Based on these numbers, the State will solicit case management providers and will award based on sufficient capacity to serve all enrollees and applicants.

The State monitors agency capacity and has re-solicited providers as needed. The State has also worked with existing agencies to increase capacity as needed within system, targeted by region as needed.

2. Describe how the State will evaluate and ensure on an ongoing basis that providers are appropriately distributed throughout the geographic regions covered by the selective contracting program so that Medicaid beneficiaries have sufficient and timely access throughout the regions affected by the program.

   In order to allow flexibility, the State enrolls case management providers in yearly agreements. The State will review on an annual basis the distribution of enrollees and applicants and will revise the number of providers accordingly. The State monitors provider capacity monthly and may solicit additional providers more frequently if needed.

   Reports in web based tracking system, LTSS, are monitored regularly including a "SPA – Capacity report". There are always a minimum of two provider agencies per region.

B. Utilization Standards

Describe the State's utilization standards specific to the selective contracting program.

1. How will the State (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State) regularly monitor(s) the selective contracting program to determine appropriate Medicaid beneficiary utilization, as defined by the utilization standard described above?

   The State maintains a case management module through the LTSS tracking system that monitors the number of case management units approved on the plan of service and billed by each provider. Reports from this system will be used to by the State to monitor service utilization.

   The State reviews supports planning billing quarterly using reports from the LTSS tracking system. The State reviews transition services billing continuously, with reports from the contractor on minimum of a monthly basis. Currently the State review all transition fund claims.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiary utilization falls below the utilization standards described above.

   Participants have case management units identified on their person-centered and Department-approved Plan of Service which is maintained in the LTSS tracking system. The number of case management units utilized is monitored via reports in the LTSS tracking system. The State monitors the total number of applicants and participants to be served against the capacity of current agencies, taking into account predetermined caseload ratios and enrollment trends. If and when the maximum capacity of current providers is expected to be reached within the next 6 months, the State will solicit additional providers. The State will also allow existing providers who have no pending CAPs to expand their capacity to meet additional need.

Based on a review of claims, there was no indication of utilization below the standard.

Part III: Quality

A. Quality Standards and Contract Monitoring

1. Describe the State's quality measurement standards specific to the selective contracting program.

   a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

      i. Regularly monitor(s) the contracted providers to determine compliance with the State's quality standards for the selective contracting program.

         Quality requirements and remediation activities will be defined in the competitive solicitation process for case management.

         The State has one reportable events policy that is used to follow-up on significant incidents and complaints for the Home and Community-Based Options waiver as well as State Plan Community First Choice and Community Personal Assistance Services programs. All providers are required to comply with the reportable events policy. Once a complaint is received by the State, staff will review the findings and supporting documentation, follow-up with appropriate entities/parties, and if necessary, determine and implement appropriate action involving the participant, provider, etc., such as recommending a Corrective Action Plan (CAP). The policy in its entirety may be found at; https://mmcp.dhmh.maryland.gov/docs/RE-POLICY-FINAL-VERSION-OHS.pdf

         Providers are required to meet certain case management standards and are monitored with regards to their performance in the matters of participant safeguards in the quality improvement-health and welfare section of the 1915(c)

application. Performance measures are outlined in the provider solicitation and agreement monitored on a quarterly basis by the State.

The State or designee conducts at least an annual review of each case management agency. N: Total number of case management oversight reviews completed annually. D: Total number of approved case management agencies.

Unlicensed providers of case management will be sent a letter of minimum qualifications they must meet. PM – Number of unlicensed case management providers who meet minimum qualifications for providing services annually. N: Number of unlicensed case management providers that meet waiver requirements. D: Number of unlicensed providers who billed for the year.

Each SPA agency had an assigned liaison to provide technical assistance and identify issues that needed remediation (not complaint with the Solicitation).

ii. Take(s) corrective action if there is a failure to comply.
The State will require a corrective action plan for a provider that fails to meet quality standards. In the event the providers fail to meet standards under the CAP, the State will take action to terminate the designation as a case management provider and transition all participants to other providers identified through the competitive solicitation process.

37 Corrective Action Plans (CAPs) were issued, and all 37 required written response and identification of an immediate plan for remediation and ongoing quality assurance plan to ensure adherence to the provider solicitation.

2. Describe the State's contract monitoring process specific to the selective contracting program.

a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

i. Regularly monitor(s) the contracted providers to determine compliance with the contractual requirements of the selective contracting program.

The State performs an annual audit of each agency. SPA liaisons at DHMH engage in ongoing monitoring of compliance, and identification of non-compliance to the provider Solicitation results in CAPs.

ii. Take(s) corrective action if there is a failure to comply.
The web-based LTSS system contains data related to service provision, including dates of services, activities performed, and billing. The contract/agreement monitor will review utilization reports to monitor timeliness and compliance.

The State will require a corrective action plan for a provider that fails to meet contractual/provider agreement requirements. In the event the providers fail to meet contractual requirements under the CAP, the State will take action based on procurement rules.

For the termination of a Supports Planning Agency, letters are sent to each participant and they are contacted by phone to notify them of the change in provider status. Participants are afforded the opportunity to choose a new Supports Planning Agency, or are assigned one automatically if they do not choose.

For the change in providers of transition funds, the State provided public notice to stakeholders and Supports Planning Agencies.

B. Coordination and Continuity of Care Standards

Describe how the State assures that coordination and continuity of care is not negatively impacted by the selective contracting program.
The selective contracting program will improve quality and oversight by limiting the number of providers of the service such that the Department may more closely monitor the provision of services. Monthly oversight of performance via reports in the LTSS tracking system of the number of units of service budgeted on plans of service, utilized by participants, time frames for enrollment, and other quality indicators becomes more manageable with fewer providers.

Adjustments are based on actual number of hours per month for FY14. Many waiver participants are eligible for and receiving CFC services. These participants receive the majority of their case management through the CFC program, which had the impact of reducing the waiver case management numbers.

Part IV: Program Operations

A. Beneficiary Information

Describe how beneficiaries will get information about the selective contracting program.

Upon application, a packet of information will be sent to applicants regarding the available providers in their geographic region. Each provider may submit a brochure for the informational packet. Applicants from nursing facilities will receive this information through the *Money Follows the Person* Options Counselors**.** The AAAs, **LHDs,** and additional providers identified through the competitive solicitation are also responsible for providing required information to enrollees.

In the event of the termination of a Supports Planning Agency, participants assigned to that agency will be notified directly. Participants are mailed letters and contacted by phone to notify them of the change in provider status. Participants are afforded the opportunity to

choose a new Supports Planning Agency, or are assigned one automatically if they do not choose.

For the change in providers of transition funds, the State provided public notice to stakeholders and Supports Planning Agencies.

B. Individuals with Special Needs.

___ The State has special processes in place for persons with special needs (Please provide detail).

Section B – Waiver Cost-Effectiveness & Efficiency

Efficient and economic provision of covered care and services:

1. Provide a description of the State's efficient and economic provision of covered care and services.

   The State estimates that applicants and participants will receive 3 hours per month of case management which equals $192.46 per month at the rate of $16.04 per 15 minute unit. The pre-waiver PMPM cost has been projected to be $230.28, based on historical PMPM costs, which were paid at a flat administrative amount per participant then adjusted for the standard 2.5% annual rate increase. These projections reflect reduced utilization of waiver case management services as many waiver participants receive the service through the Community First Choice state plan program. The state share is made up of combined local and state funds.

2. Project the waiver expenditures for the upcoming waiver period.

   Year 1 from: 10/1/2016 to 6/30/2017

   Trend rate from current expenditures (or historical figures): N/A %

Projected pre-waiver cost	$ 8,310,760
Projected Waiver cost	$ 6,945,850
Difference:	$ 1,364,910

   Year 2 from: 7/1/2017 to 6/30/2018

   Trend rate from current expenditures (or historical figures): 2.5 %

Projected pre-waiver cost	$ 12,618,297
Projected Waiver cost	$ 10,636,568
Difference:	$ 1,981,729

Year 3 (if applicable) from: 7/1/2018 to 6/30/2019

Trend rate from current expenditures (or historical figures): 2.5 %

Projected pre-waiver cost	$ 14,368,965
Projected Waiver cost	$ 12,216,278
Difference:	$ 2,152,687

Year 4 (if applicable) from: 7/1/2019 to 6/30/2020

Trend rate from current expenditures (or historical figures): 2.5 %

Projected pre-waiver cost	$ 16,362,521
Projected Waiver cost	$ 14,030,602
Difference:	$ 2,331,919

Year 5 (if applicable) from: 7/1/2020 to 6/30/2021

Trend rate from current expenditures (or historical figures): 2.5 %

Projected pre-waiver cost	$ 19,420,100
Projected Waiver cost	$ 16,795,395
Difference:	$ 2,624,705